

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33409	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 000	INITIAL COMMENTS An unannounced licensure complaint investigation survey, CCR# 2016010647, CCR# 2016010959, CCR# 2016011085, CCR# 2016011361, CCR# 2016011367, CCR# 2016011369, CCR# 2016011373, CCR# 2016011421, CCR# 2016011773 and CCR# 2016011905 was commenced on _____ and concluded on _____ at Sandy Pines, Residential Treatment Center for Children and Adolescents Facility, License Number 52. CCR# 2016010647 - allegation not substantiated; CCR# 2016010959 - allegation substantiated with deficient practice; CCR# 2016011085 - one allegation related to prevention of _____ substantiated without deficient practice; CCR# 2016011361 - all three allegations were not substantiated; CCR# 2016011367 - allegation related to _____ substantiated without deficient practice; CCR# 2016011369 - allegations were not substantiated; CCR# 2016011373 - allegations were not substantiated; CCR# 2016011421 - allegations were not substantiated; CCR# 2016011773 - the allegations were not substantiated and CCR# 2016011905 - the allegation related to _____ was substantiated without deficient practice. The facility had deficiencies at the time of the investigation. C 034 65E-9.005(5)(b)1, F.A.C. Operating - Facility C 034 Interior Accommod	C 000	By submitting this Plan of Correction SandyPines does not admit that it violated the regulations. SandyPines reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency. Plan of Correction: The facility ensures the privacy of all residents, including window coverings in resident's _____. 1. _____ to have lack of window covering; window treatment added to window encasement and locked. Staff provided reinforcement for identification of privacy issues through work order system. Completion Date: Completed _____, 2016 Person Responsible: Director of Plant Operations Monitoring Plan: Daily rounds checklist for new electronic work order system includes preventative maintenance checklist for resident _____ to include window covering and privacy provisions.

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

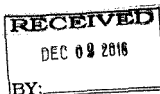
(X8) DATE

STATE FORM

www

1R7D11

If continuation sheet 1 of 18



PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
C 034	Continued From page 1 (5)(b) Interior accommodations. 1. The facility's space and furnishings shall enable staff to respect the child's right to privacy and provide adequate supervision. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the privacy of 1 of 12 sampled residents (Resident 12) as evidenced by lack of window coverings in the resident's The findings included: Observation , on _____, at approximately 10:00 AM with the Director of Plant Operations, revealed that Resident #12's _____, which was shared with another resident, included a large window with a view of the area outside of the building and this window lacked any means to cover it, to ensure the privacy of the residents. The Director of Plant Operations stated, during an interview, on _____, at approximately 10:00 AM that other residents broke the window coverings, but reported that she did not know when this occurred. In an interview conducted on _____ at 3:21 PM with Resident #12, the resident reported that the resident moved to their current _____ "like a month ago," reported that the window failed to have any methods to cover it at the time of the move and remained that way to date.		C 034		
C 043	65E-9.005(5)(b)10,F.A.C. Operating Stds - Facility (5)(b)10. _____ shall be provided and shall be separated from halls, corridors and other _____ by floor to ceiling walls. Children shall not have to go through another child's _____ get		C 043	Plan of Correction: Small bottles of liquid hand soap and paper towels have been placed on each sink counter in each	

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(K4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 043	Continued From page 2 to a. Each have: a. At least one toilet, washbasin, and tub or shower easily accessible to the each six children; b. When multiple toilets are located in a single they shall be separated by individual toilet stalls to provide individual privacy; c. with non-slip surfaces in showers or tubs; d. Toilet paper and holders, individual hand towels or disposable paper towels and soap dispensers; e. Distortion-free mirrors at a height convenient for use by children; f. A place for toiletry storage; and g. In a facility that houses children with physical that limit mobility, all toilet and bathing areas shall meet the requirements of the Florida Building Code for accessibility. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that each resident individual hand towels or disposable paper towels and soap dispensers, a total of 20 on 6 of 6 units This affected all the residents in the facility, a total of 128 residents on The findings included: Observation conducted on starting at 9:39 AM with the Director of Plant Operations revealed that a total of 20 on 6 of 6 units included a shower, toilet and hand washing sink; however, the failed to contain any individual hand towels or disposable paper towels and soap dispensers. The Director of Plan Operations acknowledged the observation, during an interview, on starting at 9:39 AM;	C 043	Completion Date: Person Responsible: Director of Nursing Monitoring Plan: <ul style="list-style-type: none">The EOC Daily Checklist, completed by the Program Supervisor on each unit, was revised on , and on the day shift and evening shift the Program Supervisor will be responsible for ensuring soap and towels are available in each resident Direct Care staff were educated onThe EOC Daily Checklist is turned in to the Residential Manager responsible for that unit each day. The Residential Manager will provide supervision and reeducation for any areas that are deficient.Random environmental checks will be completed by Residential Managers and Nurse Managers to monitor compliance.

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC5700060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33489	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 043	Continued From page 3 stated that none of the _____ were equipped with towels/paper towels and soap dispensers and reported that this was because of resident safety.	C 043	
C 045	65E-9.005(5)(b)12, F.A.C. Operating Facility Seclusion (5)(b)12. A _____ meet the following standards: a. Be a single _____ at least 50 square feet and shall be constructed to minimize the child's hiding, escape, injury or _____ b. Allow staff full view of the resident in all areas of the _____ outside of the _____ c. Doors. (I) Doors will be made of solid-core hardwood, metal or other hard, shatter-resistant material. (II) Doors must open outward and lock using a keyless locking device that will unlock upon activation of building fire alarm and will _____ safe open on loss of power to the device. (III) The door will have no other features greater than eighteen inches from the floor to which cloth or other material may be securely hung or tied. d. Floors and walls. (I) Floors and walls will be solid, smooth, and high impact resistant without metal or other _____ (II) Walls will lack features that are higher than eighteen inches from the floor to which cloth or other material may be securely hung or tied. (III) Floor tiles and baseboards are acceptable if attached securely to the floor and walls. e. Ceilings less than nine feet above the floor shall be monolithic with no appendages that can	C 045	Plan of Correction: The facility now ensures all standards are met for 1. All _____ were inspected for any deficiencies. 2. Deficiencies were identified with contracted vendor and a plan for repair was created that included - stripping of paint to prevent door jamb sticking, reinforcement of hinges. 3. Deficiencies were identified with Plant Operations staff - ceiling grid was found to be incomplete and tiles found on the floor in _____ 4. Repairs and replacements were made to correct all deficiencies. Staff provided reinforcement for identification of privacy issues through work order system. Completion Date: Door correction was made _____, 2016 and ceiling tile correction was made _____, 2016. Person Responsible: Director of Plant Operations

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 045	Continued From page 4 be securely grasped or tied onto with cloth or other material. f. Vents less than nine feet above the floor will be covered with small wire mesh, a metal plate, or other high-impact-resistant material (with holes no larger than three-sixteenth inch) in such a way that one would be unable to securely tie or hang cloth or other material from it and have no exposed sharp edges. g. Lighting. (i) Lighting less than nine feet above the floor will: (A) Be recessed and covered with shatter-resistant material; (B) Have no sharp exposed edges and lack space between it and the ceiling (or other mounting surface); (C) Not possess features to which cloth or other material can be securely tied or hung; (ii) The lighting fixture need not be recessed if it is security-rated to withstand high impact and has a shatter-resistant cover. (iii) Material used to fill space between the fixture and the mounting surface will be hard epoxy or other material that cannot be easily removed. h. Mirrors and cameras. If mirrors and cameras are located in the _____ are less than nine feet above the floor, they will: (i) Be covered with shatter-resistant material; (ii) Have no sharp exposed edges and lack space between them and the ceiling (or other mounting surface); (iii) Not possess features to which cloth or other material can be securely tied or hung; i. Sprinklers. Sprinklers less than nine feet above the floor will:	C 045	Monitoring Plan: Daily rounds checklist for new electronic work order system. Includes preventative maintenance for assuring that doors provide full view of the residents, are in good repair, and that ceiling tiles are in positive repair.	

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 045	Continued From page 5 (I) Be recessed inside a cone-shaped or other suitable housing onto which cloth or other material cannot be securely tied or hung; sprinkler systems shall be installed in accordance with National Fire Protection Association Standard 13; (II) Lack space between the base of the housing and the surface to which it is attached; (III) Will use material to fill between the fixture and the ceiling that is hard epoxy or other material that cannot be easily removed. j. Windows. (I) Windows, when present, will be made of shatter-resistant material. (II) Any glass window that is not shatter resistant will be covered with a security-rated screen or other material that prevents access to the glass. (III) Window cranks will be flush with the window. k. A toilet be conveniently located near the entering into or through a common use area. It shall not open directly into or be located within the Toilets and sinks will be smooth and devoid of handles or parts to which cloth or other material could be securely tied or hung. l. Smoke detectors. (I) Smoke detectors less than nine feet above the floor will be recessed in the wall or ceiling, or enclosed in small wire mesh or other suitable material housing that prevents access to the smoke detector. (II) The wire mesh or other enclosure will have holes that are not larger than three-sixteenth inch and lack features to which cloth or other material can be securely tied or hung and shall not prevent the smoke detector from properly	C 045	

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 045	Continued From page 6 functioning in accordance with National Fire Protection Association, 72, National Fire Alarm Code. m. Electrical outlets. (I) Electrical outlets are not permitted. (II) Electrical switches, e.g., to adjust lighting, are permissible if switches cannot be removed by the child or otherwise manipulated to gain access to the wiring. (III) Switches will not protrude so far that they permit serious self-injury. n. Beds when present will: (I) Be made of metal, heavy molded plastic, or other solid impact resistant material; (II) Be secured to the floor or wall to prevent the child from standing it upright and using it as a prop; and (III) Lack features to which cloth or other material can be securely tied, if it is higher than twenty-four inches above the floor. o. Mattresses and blankets. (I) Each child placed in _____ will have immediate access to one plastic or vinyl-covered mattress and at least one fire retardant, triple-stitched blanket made of tear resistant material. (II) Mattresses and blankets will be cleaned after each use, prior to being used by another child. p. Each _____ be inspected and certified as compliant with the above standards at least yearly and at any time damage or structural change occur. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility	C 045	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 045	Continued From page 7 failed to ensure that the facility's staff had full view of the residents at all times as evidenced by the door of 1 of 4 sampled being closed and with a sign, "out of order" without evidence of a planned repair, the door to 1 of 4 being unable to be opened and failed to maintain 1 of 2 sampled for the observed with two missing ceiling tiles above the sink that allowed for the exposing of the ceiling tile rails and the inside of the roof. The findings included: 1. Observation conducted on at approximately 10:00 AM revealed that the door to 1 of 4 was closed, with an "out of order" sign. The Maintenance Director reported, on at approximately 10:00 AM, during an interview that although she had not put a in for the repair of the door, there were contractors on site repairing other doors and the contractors would repair the door; however, there was no evidence of documentation related to the planned repair. Observation on at approximately 3:15 PM with the Clinical Director revealed that the door to another open and the there was no "Out of Order" sign or any other notice documenting that this door was not functioning; the surveyor closed the door on at approximately 3:15 PM but was unable to open it and the Clinical Director attempted to open the door, but was also not successful in opening it. Observations on at approximately 4:00 PM with the Maintenance Director and the Director of Nursing (DON) revealed that this door was still closed, with no evidence of a sign that	C 045	

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2016
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SANDY PINES

11301 SE TEQUESTA TERRACE
TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------------	--	---------------------	--	--------------------------

C 045 Continued From page 8

C 045

documented this door was not functioning properly. The Maintenance Director stated, during an interview, on _____ at approximately 4:00 PM that a contractor was assessing the door earlier that day and left it open; stated that she did not know why the contractor had removed the "Out of Order" sign; stated that she had been responsible for supervising the contractor but had not noticed that he had removed the sign and left the door open and the Maintenance Director reported that "there is a trick to it" related to opening the door, but was observed unable to open it after several attempts.

2. Observations, conducted on _____ at approximately 10:00 AM with the Maintenance Director, revealed that the _____ one of two _____ had two missing ceiling tiles above the sink that allowed for the exposing of the ceiling tile rails and the inside of the roof and there was a piece of ceiling tile resting next to the toilet.

The participants, the Maintenance Director and the Clinical Director, acknowledged the observations, during an interview, on _____ at approximately 10:00 AM.

C 052 65E-9.005(7)(a-b), F.A.C. Operating
Stds-Housekeeping Clean/Safe/Vented

C 052

(7) Housekeeping.

(a) The facility and its contents shall be kept free from dust, dirt, debris and noxious odors.

(b) All _____ and corridors shall be maintained in a clean, safe, and orderly condition, and shall be properly _____ to prevent condensation, mold growth, and noxious odors.

Plan of Correction:

The facility now maintains all _____ a clean, safe, and orderly condition.

1. _____ surveyed for excessive dust on air conditioner vents.
2. _____ surveyed for stains on vents.
3. All vents in Sea Turtle, Pelican, and Starfish were removed and thoroughly cleaned for stains and dust.

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/201
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 052	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain all and corridors free from dust, dirt and debris in a clean, safe and orderly condition for 3 of 6 sampled units, Sea Turtle Unit; Pelican Unit; and Starfish Unit. The findings included: Observation, with the Director of Plant Operations completed on at 9:39 AM reveals the following: Sea Turtle Unit- -air conditioner vents and intake vents caked with dust; the air conditioner vent had rust colored stains and was soiled; -air conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with dust and -air conditioner vents and intake vents caked with dust and a brown colored stain across the vent. Pelican Unit- -air conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with dust and the vent had rust colored stains; -air conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with dust; -air conditioner vents and intake conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with dust and -air conditioner vents and intake vents caked with dust. Starfish Unit- -air conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with	C 052	4. Contract with current housekeeping vendor discontinued. 5. Quarterly review of progress to be reported at the Committee of the Whole, with review of new housekeeping contract at the six- month and year mark. New housekeeping vendor start date provided. Completion Date: Cleaning of grates completed on , 2016. New company started , 2016. Person Responsible: Director of Plant Operations Monitoring Plan: The new housekeeping company has a more detailed work schedule and checklist than previous company. Thorough patient maintenance checklist is being implemented to ensure all light fixtures are free of stickers, dust, or grime, shower curtains have regular deep cleaning to prevent build up, door hooks with collapsible features operate as intended, air vents are free of dust. Administrative oversight will assure positive changes through electronic work order system usage and oversight of new contracted personnel with quarterly review at the Committee of the Whole and Environment of Care Committee.

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 052	Continued From page 10 dust; - air conditioner vents and intake vents caked with dust and dust from the was observed to be falling onto the light and bed, at the head of the bed; -air conditioner vents and intake vents caked with dust and large-air conditioner vent with a rust colored substance; Room 205-air conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with dust; -air conditioner vents and intake vents caked with dust and conditioner vents and intake vents caked with dust. The Director of Plant Operations acknowledged the observations on at 9:39 AM, during an interview.	C 052		
C 053	65E-9.005(7)(c-d), F.A.C. Operating -Housekeeping Walls/Ceiling/Bed (7) Housekeeping (c) All walls and ceilings, including doors, windows, skylights, screens, and similar closures shall be kept clean. (d) All mattresses, pillows, and other bedding; window coverings, including curtains, blinds, and shades, cubicle curtains and privacy screens; and furniture shall be kept clean. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment for 5 of 6 sampled units, Sea Turtle, Pelican, Star Fish, Seagull and Dolphin Unit. The findings included:	C 053	Plan of Correction: The facility now provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment in all units. 1. Survey of conducted to assess needs. 2. Ceilings cleaned and repainted where stains were found. 3. Contract with current housekeeping vendor discontinued. 4. New housekeeping vendor start date provided. Detailed check list for cleaning priorities created with new vendor. 5. Ongoing survey of to be conducted on preventative maintenance schedule built into new work order system. Deep clean of resident determined to be needed, date scheduled.	

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 053	Continued From page 11 Observation, conducted on _____ at 9:39 AM, with the Director of Plant Operations reveals: Sea Turtle Unit-2 broken cabinet doors in the Day _____ the Day _____ of the refrigerator was observed to be coated with dust. The light over one of the resident's beds does not work when turned on and Room 404-The electrical outlet on the wall by the window is cracked; Pelican Unit- _____-caulking around the sink coming off. - wall by handrail has a brown substance running down wall outside _____ a rust colored substance above the door. -black substance on the rim of window by bed; a mattress in this _____ torn and peeling paint observed on the wall in the _____ -The wall outside of the _____ paint peeling off the wall. -The walls are chipped and cracked. The door frame has paint coming off. -base board behind the sink is coming away from the wall and the window has a black substance around the frame. Star Fish Unit-The refrigerator's rubber seal is torn and is coming away from the door. - The safety hook in _____ not release. -The vinyl base board, on the wall by window, is torn. -The caulking around sink is stained brown. -The caulking around the sink is coming off and the vinyl base board is coming away from the wall. -The window blinds are missing from the window.		C 053	Completion Date: Cleaning of ceilings completed on _____, 2016. New company to start _____, 2016. Deep clean of resident _____ to be completed 28, 2016. Meetings with outgoing company took place on _____ and 4 th to ensure a high level of performance was maintained until company's exit, this included a thorough review of all tasks to be accomplished. Person Responsible: Director of Plant Operations Monitoring Plan: The new housekeeping company has a more detailed work schedule and checklist than previous company. Thorough patient _____ maintenance checklist is being implemented to ensure all light fixtures are free of stickers, dust, or grime, shower curtains have regular deep cleaning to prevent build up, door hooks with collapsible features operate as intended, air vents are free of dust. Administrative oversight will assure positive changes through electronic work order system usage and oversight of new contracted personnel with quarterly review at the Committee of the Whole and Environment of Care Committee.

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 053	Continued From page 12 - The glass window pane has a large crack going across the window. Seagull Unit- -The mattress does not fit the bed frame. White substance observed, on the ceiling and on the walls. Patches on walls not painted nor sanded. Dried paper like substances on the ceiling in the Dolphin Unit- -Dried paper like substances on the ceiling - paint is peeling on the walls. The Director of Plant Operations acknowledged the findings, during an interview on _____ at 9:39 AM.	C 053	
C 089	65E-9.006(7)(j-n), F.A.C. Hlth/Med/EmerMed/Psych Svcs Emergencies (7) Health, medical, and emergency medical and services. (j) All staff shall have training in the handling of emergency medical situations. (k) Emergency medical services shall be available within 45 minutes, 24 hours a day, seven days a week. (l) The program physician's name and telephone number shall be clearly posted in areas accessible by staff and others within the facility. (m) There shall be a first aid kit available to staff for each unit or building for facilities with multiple units or buildings and one per facility for single unit or building facilities. Contents of the first-aid kits shall be selected by the medical staff. (n) The provider shall have a written agreement with a licensed hospital verifying that routine and emergency hospitalization will be available.	C 089	Plan of Correction: Signed affiliate agreement is on file. Completion Date: Person Responsible: Director of Business Development Monitoring Plan: Affiliate agreements do not have an expiration date, but will be reviewed annually, in _____, to ensure compliance and be updated if necessary.

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
C 089	Continued From page 13 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an affiliation or written transfer agreement with one of more licensed hospitals to receive residents in case of an emergency.	C 089		
	The findings included: Review on of the facility's transfer agreements revealed no evidence of documentation that the facility had an affiliation or written transfer agreement with one of more licensed hospitals to receive residents in case of an emergency. In an interview conducted on at 12:30 PM with the Risk Manager, the Risk Manager reported that although she remembers that the facility had such an affiliation/agreement during previous surveys and inspections and the facility was unable to locate the evidence of documentation of an affiliation/agreement.			
C 091	65E-9.006(8)(b), F.A.C. Program - Med Admin Locked Storage (8) Administration of medication. (b) All medicines and drugs shall be kept in a double locked location. Prescription medications shall be prescribed only by a duly licensed physician or an ARNP or physician's assistant working under the direction of a licensed physician. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store medication in the required double locked location, for 2 of 2 sampled medication located in the facility.	C 091	Plan of Correction: <ul style="list-style-type: none"> Effective , the locked towers adjacent to the Med Dispense machine in each medication used to store any medications prepared before the time of administration. Nurses were educated in Nurses meetings and about the requirement that medications must be double locked, and that the locked medication is the first safe guard, and the locked tower is the second. Signed attestation of understanding to be completed and placed in each nurse's file. 	

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 091	Continued From page 14 The findings include: On _____ at 03:10 PM., during the tour of the facility's medication storage _____, located on the Sea Turtle/Pelican unit, observation revealed more than 10 individually labeled, filled with medications, resident's medication cups were observed sitting on an open tray, without benefit of a double locked location. Interview, on _____ at 03:10 PM., with Staff #L, a Registered Nurse, revealed that the medication in this open tray was prepared for the evening medication administration; Staff # L stated that the medication is left out on the tray and the medication did not have to be locked up since there are no _____ and the _____ is always locked. On _____ at 3:25 PM, during the tour of the facility's medication storage _____, located on the Dolphin/Seagull unit, observation revealed more than 10 individually labeled, filled with medications, resident's medication cups were observed sitting on an open tray, without benefit of a double locked location. Interview, on _____ at 3:25 PM with Staff #J and #K, who are Registered Nurses, revealed that the medication in this open tray was prepared for the evening medication administration; stated that the medication is left out on the tray and the medication did not have to be locked up since there are no _____ and the _____ is always locked.	C 091	<ul style="list-style-type: none"> Lockable medication carts have been ordered (arrived _____), and once assembled, will be placed in each medication _____ store medications prepared before the time of administration. Completion Date: _____ Person Responsible: Director of Nursing Monitoring Plan: <ul style="list-style-type: none"> Nurse Managers will monitor for compliance during their daily rounding on their units, and provide reeducation and supervision if medications are found to not be double locked. Pharmacist and Pharmacy tech will check for compliance when they are stocking the Med Dispense machine, and report any issues with compliance to the Nurse Manager responsible for that unit Plan of Correction: <ul style="list-style-type: none"> Reeducation of all Nursing staff (MHT's and Nurses) on the expectations and process for completing Q 15 minute checks. Signed attestation to be completed and placed in each employee's file. 	
C 097	65E-9.006(12)(b-c), F.A.C. Program - Child's Record Content (12) Child's record. (b) The provider shall develop an individualized record for each child. The form and detail of the records may vary but shall, at a minimum,	C 097		

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 097	Continued From page 15 include: 1. Identification and contact information, including the child's name, date of birth, Social Security number, gender, race, school and grade, date of admission, and the parent or guardian's name, address, home and work telephone numbers; 2. Source of referral; 3. Reason for referral to residential treatment, e.g., chief complaint, presenting problem(s); 4. Record of the complete assessment; 5. DSM diagnosis; 6. Treatment plan; 7. Medication history; 8. Record of medication administered by program staff, including type of medication, dosages, frequency of administration, persons who administered each dose, and method of administration; 9. Documentation of course of treatment and all evaluations and examinations, including those from other facilities, such as emergency or general hospitals; 10. Progress notes; 11. Treatment summaries; 12. Consultation reports; 13. Informed consent forms; 14. A chronological listing of previous placements, including the dates of admission and discharge, and dependency and delinquency actions affecting the minor's legal status; 15. Written individual education plan for the child, when applicable; 16. The discharge summary, which shall include the initial diagnosis, clinical summary, treatment outcomes, assessment of child's treatment needs at discharge, the name, address and phone number of the person to whom the child was discharged and follow-up plans. In the event of _____, a summary shall be added to the record	C 097	<ul style="list-style-type: none">• Outlets will be reported to the Nurse Manager of the unit and the CNO.• New model for provision of care being developed, which will include a Nursing Unit Coordinator position on each unit, that will be responsible and accountable for milieu and staff supervision and concurrent monitoring of completion of Q15 minute checks. (This model will take several months to implement). Completion Date: Person Responsible: Director of Nursing Monitoring Plan: <ul style="list-style-type: none">• Concurrent audit to be completed at the end of each shift by the Program Supervisor, and turned in daily to the Residential Managers after relevant training. Issues with noncompliance will result in accountability to include progressive discipline of the employee.

PRINTED: 11/22/2016
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
C 097	Continued From page 16 and shall include circumstances leading to the All discharge summaries shall be signed by the clinical or medical director; 17. For out of state children, copies of completed Interstate compact ICPC 100A and ICPC 100B forms (2002) and a copy of each Interstate Compact Transmittal Memorandum and any attachments thereto that were sent to the Residential Treatment Center by the department's Interstate Compact on the Placement of Children Office; 18. Documentation of any use of or time out; 19. A copy of each incident report that includes a clear description of each incident; the time, place, and names of individuals involved; witnesses; nature of injuries, if any; cause, if known; action(s) taken; a description of medical services provided, if any; by whom such services were provided; and any steps taken to prevent a recurrence. Incident reports shall be completed by the individual having first-hand knowledge of the incident, including paid and volunteer staff, emergency or temporary staff, and student interns; and 20. Documentation that all of the various notices and copies required by these rules were properly given. (c) Records of discharged children shall be completed within 15 business days following discharge. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the resident's records for 2 of 12 sampled residents were completely documented (Resident #9 and #11).	C 097	

PRINTED: 11/22/2018
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC57000560	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/27/2016
NAME OF PROVIDER OR SUPPLIER SANDY PINES		STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
C 097	Continued From page 17 The finding included: Review on _____ of Resident #9's record on _____ revealed that the resident was admitted to the facility on _____ and discharged home on _____ in the afternoon. Review of this resident's record revealed documentation that on _____ the resident had shown inappropriate behavior on the unit and was moved to a different unit. Further review of the resident's record, for documentation of supervision, from _____ to _____ revealed that staff failed to consistently document that they had performed the required "check" on a resident at least every 15 minutes on _____ at 10:15 PM and 10:30 PM; on _____ at 11:45 AM and 12:00 PM, 12:15 PM, 3:00 PM and 3:15 PM. In an interview conducted on _____ at 12:58 PM with Resident #9, the resident stated that they were switched to a different unit after _____. 2) Review on _____ of Resident #11's record revealed that the resident was admitted to the facility on _____. Further review of the resident's record revealed that staff failed to document the physician's ordered routine supervision on _____ from 11:45 AM through 1:00 PM, on _____ from 2:45 PM through 3:15 PM, on _____ from 2:15 PM through 3:00 PM on _____ from 2:45 PM through 4:15 PM and the resident's record failed to include any evidence of documentation to justify the lack of documentation. In an interview conducted on _____ at 12:57 PM with the Director of Nursing (DON), the DON acknowledged the lack of documentation.	C 097		



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

January 1, 2016

Administrator
Sandy Pines
11301 S.E. Tequesta Terrace
Tequesta, FL 33469

RE: CCR# 2016010647, CCR# 2016010959, CCR# 2016011085, CCR# 2016011361, CCR# 2016011367, CCR# 2016011369, CCR# 2016011373, CCR# 2016011421, CCR# 2016011773 and CCR3 2016011905

Dear Administrator:

This letter reports the findings of a state complaint investigation survey that was concluded on January 1, 2016 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies within ten calendar days of receipt of this faxed report. You will not receive a copy of this report in the mail; you will only receive this faxed report. All deficiencies shall be corrected no later than January 1, 2016.

The plan of correction must include the following:

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

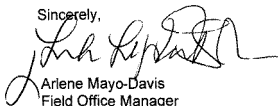


Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ariene Mayo-Davis', written over the printed name.

Ariene Mayo-Davis
Field Office Manager

AMD
Enclosure: State Form 3020

TBB2